STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS

Department of Behavioral Healthcare, Developmental Disabilities and Hospitals

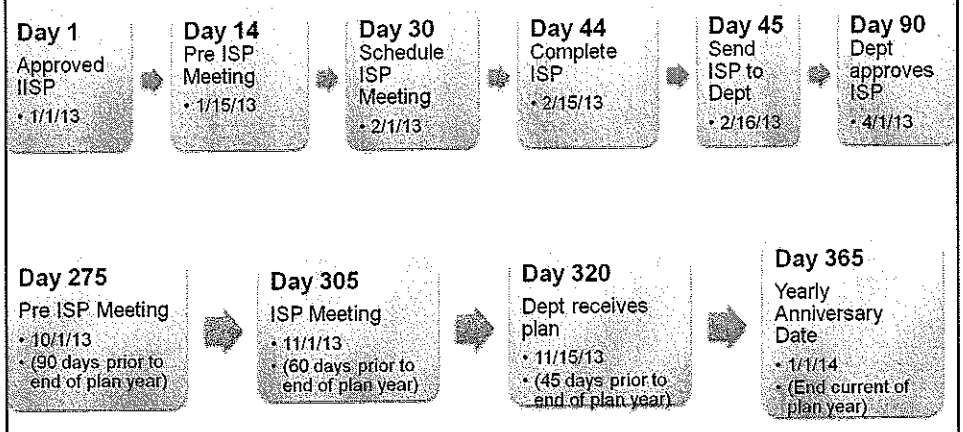
Individualized Service Plan (ISP)

Training session

January 17, 2013

IISP and ISP Timeline

New Participant - First Year of services



Sample Interim Individualized Service Plan (IISP)

IISP Form

See following pages for example

Sample Individualized Service Plan (ISP)

ISP Form

See following pages for examples

Frequently Asked Individualized Service Plan Questions

What information does the ISP have to include related to the participant's diagnosis?
(Related to item# 4 on ISP and addendum 4)

- Regulation 37.12 d- The ISP document shall include documentation of the need for specialized health care, health maintenance services; identification of the person or provider responsible for assuring that the services are provided; and documentation of all of a Participant's diagnoses

-The Diagnosis can be coded from either the Diagnostic and Statistical Manual of Mental Disorders (DSM) or the International Statistical Classification of Diseases and Related Health Problems (ICD).

What Qualifications are needed to make the diagnosis?

- For Developmental Disability Diagnosis:
  - A) Physician- For intellectual disabilities, testing is required to substantiate the diagnosis
  - B) Licensed Psychologist substantiated through testing

- For a Behavioral Health Diagnosis (Psychiatric and Substance Abuse) :
- Psychiatric
  - A) Physician
  - B) Licensed Mental Health Professionals such as a psychiatrist, clinical social worker, psychologist, nurse and mental health counselor.
- Substance Abuse
  - C) Section 9.10 of the Licensing of Behavioral Healthcare Organizations for:
- 9.10.1 Licensed Independent Practitioner
- 9.10.2 Licensed Chemical Dependency Clinical Supervisor
- 9.10.3 Licensed Chemical Dependency Professional or Certified Co-Occurring Disorder Professional-"Diplomate" (CCDP-D) or Certified Co-Occurring Disorder Professional

- For a Medical/Other Diagnoses
  - A) Physician

What is the Department's Role with assisting obtaining diagnostic information?

- For all new Participants the Eligibility Unit of Social Services will begin the process to obtain paperwork from identified qualified individuals who can provide diagnostic information.

- The information can be obtained by the support coordinator of the Developmental Disabilities Organization (DDO) who is selected by the participant

For Participants without current Diagnostic information in their record, what should be done?

- The support coordinator of the DDO is to coordinate care with a qualified professional to obtain the information.

Can the DDO use existing documentation in the participants record for diagnosis and Code for the ISP?

- Yes, provided that the diagnosis and Code is current and accurate.
- For each annual ISP the Diagnosis shall be reviewed and updated annually

Is the New ISP form required for Participants who choose self-directed care?

- Yes. Additional information may be added to the form if needed

What is the start date for use of the IISP and ISP forms?

- Start date will be February 4, 2013. Any plan that has been signed and dated prior to that date will be accepted and not need to be submitted on the new ISP form.

For Participants transferring to another agency, what form (ISP or IISP) should the receiving agency complete?

- The receiving agency shall update the existing ISP with any changes to services
- That ISP will be effective until their next anniversary date

Who do we contact for additional ISP questions?

- Contact projectsustainability@bhddh.ri.gov

IISP and ISP Timeline

New Participant - First Year of services

Day 1
Approved IISP
- 1/1/13

Day 14
Pre ISP Meeting
- 1/15/13

Day 30
Schedule ISP Meeting
- 2/1/13

Day 44
Complete ISP
- 2/15/13

Day 45
Send ISP to Dept
- 2/16/13

Day 90
Dept approves ISP
- 4/1/13

Day 275
Pre ISP Meeting
- 10/1/13
- (90 days prior to end of plan year)

Day 305
ISP Meeting
- 11/1/13
- (60 days prior to end of plan year)

Day 320
Dept receives plan
- 11/15/13
- (45 days prior to end of plan year)

Day 365
Yearly Anniversary Date
- 1/1/14
- (End current of plan year)

STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS

Department of Behavioral Healthcare, Developmental Disabilities and Hospitals
SOCIAL SERVICES
6 Harrington Road
Cranston, RI 02920-3080

TEL: (401) 462-3421
FAX: (401) 462-2558

NAME OF PERSON: Joe G

SOCIAL SECURITY NUMBER: 000-00-0123

CASE MANAGEMENT AGENCY/DDO: ABC Agency

ASSIGNED TIER C

x 90 DAY PLAN and TIER SERVICE PACKAGE

EMERGENCY SITUATION – Received approval from the Director/Administrator at BHDDH

Name of BHDDH Administrator _____ Date _____

Date Sent to Dept: 12/31/2012

Date Received by Dept: 12/31/2012

STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS

Department of Behavioral Healthcare, Developmental Disabilities and Hospitals
SOCIAL SERVICES
6 Harrington Road
Cranston, RI 02920-3080

TEL: (401) 462-3421
FAX: (401) 462-2558

Interim Individualized Service Plan (IISP)

Name: Joe G Date Plan Written: 12/30/2012

Social Security Number: 000-00-0123 Date Of Birth: 2/9/1992

Shared Living Arrangement Contractor (If Applicable): _____

Legal Guardian Name (If Applicable): Joe is own legal guardian

Address: 123 Main Rd. Anywhere, RI

Residential Status: Living with Family

Agency/DDO #1: ABC Agency

Agency/DDO #2: XYZ Agency

Agency/DDO #3: _____

Requested Start Date: 1/1/2013
(Addendum 1-IISP Attendance Sheet must be completed)

☆ The Interim Individualized Service Plan (IISP) describes specific supports and services authorized by the Department for a person with developmental disabilities in such areas as vocational, social, medical and supportive living, and includes deliverable ninety (90) days goals and objectives responsive to the individual needs of the Participant.

☆ If Participant is required to have a Medical Treatment Plan and/or a Behavioral Treatment Plan, the plan(s) must be attached to this IISP.

1. **Participant's Goals:** Please describe what you want to happen in the next ninety (90) days and list the things that are the MOST important to you.
(Addendum 2- Summary of IISP Goals must be completed for each Agency/DDO)

Agency/DDO #1 Goals:
Joe will take his medications daily. Joe will attend all scheduled medical appointments. Joe would like to participate in Petalworks and Meals on Wheels. Joe will maintain weekly visits with his friends with assistance from his provider for scheduling and transportation. Joe would like to attend ABC day program 3 days per week.

Agency/DDO #2 Goals:
Joe would like to attend the day program with XYZ 2 days per week. Joe would like to participate in the Art program. Joe would like transportation to and from his home to his day program. Joe will take his medication daily.

Agency/DDO #3 Goals:

2. **Agency/DDO Responsibilities**: Please provide an overall description of the support that the Agency/DDO will provide based upon the units of service on the attached Purchase Order.
(Addendum 3- Schedule of Services must be completed by each Agency/DDO.
Be sure to indentify who (ie DDO, Participant, Family, etc.) will be providing the transportation).

Agency/DDO #1 Responsibilities:
ABC Agency will provide coordination and case management. We will also ensure coordination of Joe's day program as well by maintaining contact with XYZ Agency and ensure services are being provided. ABC will provide Day Program 3 days/week. ABC will provide community supports and transportation to and from day program (5 days/week).

Agency/DDO #2 Responsibilities:
XYZ Agency will provide day program 2 days per week. Joe will be provided a schedule of special monthly activities provided by XYZ Agency as well as the monthly snack and lunch menu.

Agency/DDO #3 Responsibilities:

3. Please describe the roles & responsibilities of the Participant/Family/Legal Guardian.

Agency/DDO #1 Roles and Responsibilities:
ABC Agency expects that Joe and his mother/guardian will maintain open communication with our agency regarding services received and any questions/concerns, satisfaction and ideas relating to this ISP. We expect that Joe and his mother will participate in annual meetings and any other meetings held on his behalf.

Agency/DDO #2 Roles and Responsibilities:
XYZ Agency expects that Joe and his mother, as well as ABC Agency will maintain open communications in regards to any questions/concerns relating to Joe and the supports that he receives from XYZ Agency. XYZ Agency expects Joe and his mother provide input annual to their satisfaction with services via a satisfaction survey.

Agency/DDO #3 Roles and Responsibilities:

Both the "Agency/DDO" and "Participant" agree to comply with all regulatory requirements regarding the notice of termination of services and transitional planning.

I, "Participant", or my representative understand and agree with the following:

- If the RI Department of Human Services or Department of Behavioral Healthcare, Developmental Disabilities & Hospitals notifies me that as part of my Waiver eligibility and per Medicaid regulation I am required to contribute to the cost of my supports, I understand and agree to pay this amount to the Agency each month. I also agree to disclose to the "Agency/DDO" my earned and unearned income when requested.

I certify that I have participated in the development of this Individualized Service Plan.

Joe G
Participant and/or Legal Guardian

12/30/2012
Date

I ABC Executive Director of "Agency/DDO" or authorized representative understand and agree with the following:

* An "Agency/DDO" representative has met with the above named individual and family member(s) and has clearly described the supports specified in this IISP that the "Agency/DDO" will provide.

· The "Agency/DDO," upon request, will assist the "Participant" in maintaining his/her Medicaid/ Waiver eligibility.

ABC — 12/30/2012

Agency/DDO #1 Executive Director/ Authorized Representative — Date

I XYZ Executive Director of "Agency/DDO" or authorized representative understand and agree with the following:

* An "Agency/DDO" representative has met with the above named individual and family member(s) and has clearly described the supports specified in this IISP that the "Agency/DDO" will provide.

· The "Agency/DDO," upon request, will assist the "Participant" in maintaining his/her Medicaid/ Waiver eligibility.

XYZ — 12/30/2012

Agency/DDO #2 Executive Director/ Authorized Representative — Date

I _____ Executive Director of "Agency/DDO" or authorized representative understand and agree with the following:

* An "Agency/DDO" representative has met with the above named individual and family member(s) and has clearly described the supports specified in this IISP that the "Agency/DDO" will provide.

· The "Agency/DDO," upon request, will assist the "Participant" in maintaining his/her Medicaid/ Waiver eligibility.

_____ — _____

Agency/DDO #3 Executive Director/ Authorized Representative — Date

Please be advised, all Participants shall be notified that they have access to free legal support regarding issues relating to services. Supports can be accessed at the RI Disability Law Center (401) 831-3150.

Date Completed: 12/31/2012

Interim Individualized Service Plan (IISP)

Attendance Sheet

Addendum 1

Participant's Information

Name: Joe G

Address: 123 Main Rd Anywhere , RI

Date of Birth 2/9/1992

Soc. Sec. No.: 000-00-0123 Phone No.: 555-1234

Meeting Information

Location: 1925 Giant Way

Date: 12/30/2012 Time: 1pm

Joe G
Participant's Signature

Jane G (Mother)
Legal Guardian Name

Legal Guardian Signature

BHDDH Social Worker
Department Representative Name

Department Representative Signature

ABC Agency
Agency/DDO Name #1

Agency/DDO Signature # 1

XYZ Agency
Agency/DDO Name #2

Agency/DDO Signature # 2

Agency/DDO Name #3

Agency/DDO Signature # 3

Name (Relationship to Participant)

Signature

Name (Relationship to Participant)

Signature

Name (Relationship to Participant)

Signature

Summary of IISP Goals
Addendum 2

Participant's Name Joe G Agency ABC & XYZ

Upcoming 90 Day Period 1/1/2013 To 4/1/2013

90 Day Goals

Type of Goal Check all that apply	Brief Description of Goal	Person(s) responsible to attain Goal
☑ Health	Joe will attend medical, vision and dental appointments	Agencies, Participant and family
	Joe will take prescribed medication daily	Agencies, Participant and family
☑ Safety	Joe will not cross the street alone while in the community	Agencies, Participant and family
☑ Social	Joe will participate in weekly visits with friend	ABC and Participant
	Joe will participate in one community outing per week	ABC and Participant
☑ Employment	Joe will volunteer for Meals on Wheels 2 days/week	ABC and Participant
	Joe will volunteer for Petalworks 1 day/week	ABC and Participant
	Joe will participant in the Art Program	XYZ and Participant
☑ Other	Complete one household chore per day	ABC, Participant and family

* Please add more pages if needed

Schedule of Services
Addendum 3

Name: Joe G

Date of Birth: 2/9/1992 | Social Security Number: 000-00-0123 | Agency/DDO #1: ABC

Agency/DDO #2: XYZ | Agency/DDO #3:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Mornings	ABC (7:30-8:30) Transport (8:30-9) have breakfast get dressed hygiene routine	ABC (7:30-8:30) Transport (8:30-9) have breakfast get dressed hygiene routine	ABC (7:30-8:30) Transport (8:30-9) have breakfast get dressed hygiene routine	ABC (7:30-8:30) Transport (8:30-9) have breakfast get dressed hygiene routine	ABC (7:30-8:30) Transport (8:30-9) have breakfast get dressed hygiene routine		
Day Hours	Day Program ABC 9-3pm ABC Transport 3-3:30	Day Program ABC 9-3pm ABC Transport 3-3:30	Day Program ABC 9-3pm ABC Transport 3-3:30	Day Program XYZ 9-3pm ABC Transport 3-3:30	Day Program XYZ 9-3pm ABC Transport 3-3:30		
Late Afternoon/ Evenings	ABC (3:30-6:30) Visit with friends Help with dinner	ABC (3:30-6:30) Community Outing Help with dinner	ABC (3:30-6:30) Help with dinner and household chores.	ABC (3:30-6:30) Help with dinner and household chores.	ABC (3:30-6:30) Help with dinner and household chores.		
Overnights							

STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS
Department of Behavioral Healthcare, Developmental Disabilities and Hospitals
SOCIAL SERVICES
6 Harrington Road
Cranston, RI 02920-3080
TEL: (401) 462-3421
FAX: (401) 462-2558

NAME OF PERSON: Joe G

SOCIAL SECURITY NUMBER: 000-00-0123

CASE MANAGEMENT AGENCY/DDO: ABC Agency

ASSIGNED TIER C

Please check the appropriate line:

X NEW PLAN AND TIER SERVICE PACKAGE

_____ ANNUAL PLAN RENEWAL WITHIN EXISTING TIER SERVICE PACKAGE
NO CHANGES TO SERVICE PACKAGE*

_____ TRANSFER OF AGENCY/DDO

Program Type:

_____ Residential From: _____ To: _____

_____ Day From: _____ To: _____

_____ Community From: _____ To: _____

Requested effective date of transfer _____

CHANGE IN TIER SERVICE PACKAGE SUPPORTED BY A SIS
****Tier Service Package changes (increase/decrease) not supported by a SIS will not be accepted.****

EMERGENCY SITUATION – Received approval from the Director/Administrator at BHDDH

Name of BHDDH Administrator _____ Date _____

Date Sent to Dept: 2/15/2013

Date Received by Dept: 2/16/2013

STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS
Department of Behavioral Healthcare, Developmental Disabilities and Hospitals
SOCIAL SERVICES
6 Harrington Road
Cranston, RI 02920-3080
TEL: (401) 462-3421
FAX: (401) 462-2558

Individualized Service Plan

Name: Joe G Date Plan Written: 2/15/2013

Social Security Number: 000-00-0123 Date Of Birth: 2/9/1982

Shared Living Arrangement Contractor (If Applicable): N/A

Legal Guardian Name (If Applicable): Joe is own legal guardian

Address: 123 Main Rd. Anywhere, RI

Residential Status: Living with Family

Agency/DDO #1: ABC Agency

Agency/DDO #2: XYZ Agency

Agency/DDO #3:

Requested Start Date: 4/1/2013 Anniversary Date 1/1/2013
(Addendum 1-ISP Attendance Sheet must be completed)

The Individualized Service Plan describes specific supports and services authorized by the Department for a person with developmental disabilities in such areas as vocational social, medical and supportive living, and includes deliverable long term goals and objectives responsive to the individual needs of the Participant. This document shall be reviewed and and revised annually and shall describe in detail the specific, clinically appropriate and individualized services authorized and funded by the Department to be provided by the Agency/DDO to the Participant, or which shall be directed by the Participant through a fiscal intermediary.

1. **Participant's Goals:** Please describe what you want to happen in the next year and list the things that are the MOST important to you.
(Addendum 2- Summary of ISP Goals must be completed for each Agency/DDO)

Agency/DDO #1 Goals:
Joe will take his medications daily. Joe will attend all scheduled medical appointments. Joe would like to participate in Petalworks and Meals on Wheels. Joe will maintain weekly visits with his friends with assistance from his provider for scheduling and transportation. Joe would like to attend ABC day program 3 days per week. Addtl info on page #9

Agency/DDO #2 Goals:
Joe would like to attend the day program with XYZ 2 days per week. Joe would like to participate in the Art program. Joe would like transportation to and from his home to his day program. Joe will take his medication daily. Joe likes to keep busy and would benefit from a set schedule. Joe would like to sign up for the Federal Lunch program.

Agency/DDO #3 Goals:

2. **Agency/DDO Responsibilities**: Please provide an overall description of the support that the Agency/DDO will provide based upon the units of service on the attached Purchase Order.
(Addendum 3- Schedule of Services must be completed by each Agency/DDO.
Be sure to indentify who (ie DDO, Participant, Family, etc.) will be providing the transportation).

Agency/DDO #1 Responsibilities:
ABC Agency will provide coordination and case management. We will also ensure coordination of Joe's day program as well by maintaining contact with XYZ Agency and ensure services are being provided. ABC will provide Day Program 3 days/week. ABC will provide community supports and transportation to and from day program (5 days/week). See page #9

Agency/DDO #2 Responsibilities:
XYZ Agency will provide day program 2 days per week. Joe will be provided a schedule of special monthly activities provided by XYZ Agency as well as the monthly snack and lunch menu. See page #9

Agency/DDO #3 Responsibilities:

3. Please describe the roles & responsibilities of the Participant/Family/Legal Guardian.

Agency/DDO #1 Roles and Responsibilities:
ABC Agency expects that Joe and his mother will maintain open communication with our agency regarding services received and any questions/concerns, satisfaction and ideas relating to this ISP. We expect that Joe and his mother will participate in annual meetings and any other meetings held on his behalf.

Agency/DDO #2 Roles and Responsibilities:
XYZ Agency expects that Joe and his mother, as well as ABC Agency will maintain open communications in regards to any questions/concerns relating to Joe and the supports that he receives from XYZ Agency. XYZ Agency expects Joe and his mother provide input annual to their satisfaction with services via a satisfaction survey. See page #9

Agency/DDO #3 Roles and Responsibilities:

4. Please provide documentation of the need for specialized health care, health maintenance services and the person or provider responsible for assuring that these services are provided. (Addendum 4-Diagnosis Form must be completed).

Agency/DDO #1 Responsibilities:
ABC Agency will make sure Joe schedules and follows through with all medical appointments. This may include dental visits, annual physicals, sick visits, psych. appointments and neurohealth appointments. At each visit a form will be completed by the physician and kept in his file. Addtl info on page #9

Agency/DDO #2 Responsibilities:
XYZ Agency will follow the seizure protocol (Health Care Plan) provided by ABC Agency and provide a copy of the seizure and provide a copy of the seizure observation form to ABC Agency. If Joe should require immediate medical attention 911 will be utilized and his mother and ABC Agency will be contacted.

Agency/DDO #3 Responsibilities:

5. Please document the need for additional evaluations or other services to be obtained and the person or provider responsible for assuring that these evaluations or services are obtained. (If the client has a Medical Plan or Behavior Plan please make note and attach)

Agency/DDO #1 Responsibilities:
Joe does have a seizure disorder as stated above. ABC Agency protocol and seizure policy is attached.

Because Joe has autism it may be difficult for him to express himself appropriately during stressful and anxious times

Agency/DDO #2 Responsibilities:
XYZ Agency will follow the seizure protocol provided by ABC Agency.

Agency/DDO #3 Responsibilities:

6. Please describe the Participant's safety skills including the level of support necessary for the Participant to evacuate a building (when warned by a signal device), the Participant's ability to adjust water temperature and the amount of time a Participant can be without supervision before the missing notification protocol is implemented.

Agency/DDO #1 Description of Participant's safety skills:
Joe needs full assistance and supervision in regards to safety. He is never left alone at home or in the community.

He needs supervision and physical assistance at all times when using kitchen appliances and cooking.

Joe may not respond to an alarm without prompting. Joe has no mobility concerns. Addtl info on page #9

Agency/DDO #2 Description of Participant's safety skills:
Joe will be in the general area of staff at all times at the day program and will be in line sight of staff while in the community.

Joe will hold the arm of staff when crossing a street or while traversing any parking area, as he has no street crossing skills

Staff will provide verbal and physical/ gestural cues in an emergency situation.

Agency/DDO #3 Description of Participant's safety skills:

7. Document how each agency/DDO intends to routinely communicate with other providers, family members, Department social worker and the Participant to promote quality care and keep everyone informed of any changes or specific issues that may arise.
(Attach copies of all current signed releases)

Agency/DDO #1 Communication plan:
ABC maintains open communication with everyone on Joe's team including his state caseworker, his mother.

Communication may be done via telephone, emails and team meetings including his annual ISP.

Anyone on Joe's team can ask for a meeting at any time. Addtl info on page #10

Agency/DDO #2 Communication plan:
XYZ will communicate daily concerns/ issues with ABC and or mother. If there are any incidents that require an incident report

a copy of the report will be forwarded to ABC and QI @ BHDDH if needed. XYZ staff will participate in the development

of his day supports and participate in the development of his ISP.

Agency/DDO #3 Communication plan:

8. Document how each agency/DDO intends to evaluate the Participant's progress towards meeting the ISP goals and objectives and the continued relevance of the ISP's objectives and strategies.

Agency/DDO #1 Attach Participant's progress data documentation sheet(s):
ABC is responsible for completing daily documentation and monthly progress notes. The daily documentation is sent to Joe's

Coordinator weekly for review and to ensure he is getting assistance with working on the goals listed in this ISP. Monthly

progress reports include any medical, behavioral and other concerns that may have arisen that month. Addtl info page #9

Agency/DDO #2 Attach Participant's progress data documentation sheet(s):
Staff will complete a daily data collection sheet as well as write progress notes as needed. Record contacts

Agency/DDO #3 Attach Participant's progress data documentation sheet(s):

9. Document all reason(s) any preference of the Participant, legal representative and/ or family members cannot be honored.

Participant preference all participant preferences are been discussed and are reflected in this ISP

Legal Representative preference

Family Member preference all family member preferences are been discussed and are reflected in this ISP

10. Document the development and availability of current natural supports including strategies to assist the Participant in establishing additional natural supports in the community.
Joe will be encouraged and supported to make new natural supports within the community. This will include community outings preferred activities with peers and continuing to see his friends. Joe will attend church on sundays and will continue to maintain relationships with friends there.

11. Document who will manage Participant funds, describe the plan for the management of Participant funds and identify Legal Guardian, Financial Power of Attorney or Representative Payee if applicable. Please remember all plans must comply with all Federal & State statutes, rules & regulations including but not limited to those of the Social Security Social Security Administration.
Joe's mother is now his rep-payee. Joe needs full assistance with all aspects of money management including saving, spending, tracking, budgeting, all bank transactions, etc. His mother will be giving Joe spending money on a weekly basis.

12. Document and justify any limitations to self-management of funds. Please send documentation of the review and approval by HRC and PRC (if applicable).
As listed above, Joe will receive full support from his mother for management of his funds. Joe needs full assistance with all aspects of money management including saving, spending, tracking, budgeting and all bank transactions.

13. Document all liberty restrictions. Include a behavioral plan to support restriction(s).
Please send documentation of the review and approval by HRC and PRC (if applicable).
Joe does not have a restrictive behavioral plan in place but if he did it would need to be approved by HRC and PRC

which guidelines are detailed in the regulations

Both the "Agency/DDO" and "Participant" agree to comply with all regulatory requirements regarding the notice of termination of services and transitional planning.

I, "Participant", or my representative understand and agree with the following:

· If the RI Department of Human Services or Department of Behavioral Healthcare, Developmental Disabilities & Hospitals notifies me that as part of my Waiver eligibility and per Medicaid regulation I am required to contribute to the cost of my supports, I understand and agree to pay this amount to the Agency each month. I also agree to disclose to the "Agency/DDO" my earned and unearned income when requested.

I certify that I have participated in the development of this Individualized Service Plan.

Joe G — Participant and/or Legal Guardian

2/15/2013 — Date

I ABC Executive Director of "Agency/DDO" or authorized representative understand and agree with the following:

* An "Agency/DDO" representative has met with the above named individual and family member(s) and has clearly described the supports specified in this ISP that the "Agency/DDO" will provide.

· The "Agency/DDO," upon request, will assist the "Participant" in maintaining his/her Medicaid/ Waiver eligibility.

ABC — Agency/DDO #1 Executive Director/ Authorized Representative

2/15/2013 — Date

I XYZ Executive Director of "Agency/DDO" or authorized representative understand and agree with the following:

* An "Agency/DDO" representative has met with the above named individual and family member(s) and has clearly described the supports specified in this ISP that the "Agency/DDO" will provide.

· The "Agency/DDO," upon request, will assist the "Participant" in maintaining his/her Medicaid/ Waiver eligibility.

XYZ
Agency/DDO #2 Executive Director/
Authorized Representative

2/15/2013
Date

I _____ Executive Director of "Agency/DDO" or authorized representative understand and agree with the following:

* An "Agency/DDO" representative has met with the above named individual and family member(s) and has clearly described the supports specified in this ISP that the "Agency/DDO" will provide.

· The "Agency/DDO," upon request, will assist the "Participant" in maintaining his/her Medicaid/ Waiver eligibility.

_____
Agency/DDO #3 Executive Director/
Authorized Representative

_____
Date

Please be advised, all participants must be notified that they have access to free legal support regarding issues relating to services. Supports can be access at the RI Disability Law Center (401) 831-3150.

Date Completed: 2/15/2013

Joe G

SSN: XXX-XX-0123

Question #1- ABC Agency: Joe will participate in community outings at least once per week. Joe will complete a household chore daily with prompts (laundry, dishes, cooking, cleaning, etc).

Question #2- ABC Agency: We will complete all paperwork regarding the services provided on a daily basis that include assistance with all of the above listed goals. Monthly home visits will be done by Joe's Coordinator along with tracking of all required documents that need to be completed.

Question #2- XYZ Agency: Joe will be offered the opportunity for Art program as well as participate in the daily activity schedule. A weekly schedule will be developed for Joe. A nurse is available at the day program should a medical emergency arise.

Question #3- XYZ Agency:. XYZ Agency expects that Joe participate in agreed upon services and notify the day program department if he will be absent (contact numbers will be provided).

Question #4- ABC Agency: Joe has a seizure disorder in which our agency protocol for reporting and responding will be followed. For any changes in his seizure activity (frequency, intensity, duration, etc.), his family will be directed to make an appointment with his neurologist which will include completing medical forms. Joe has routine visits for medication management, any changes in his emotional health and well-being will be discussed at these appointments and with his Coordinator. Any changes in Joe's medical status will always include communication with his mother. Incident reports will be completed as necessary and QI will be contacted when necessary as well. 911 will be utilized for all emergency situations.

Question #6- ABC Agency: If Joe gets lost while in the community, his Coordinator will be contacted immediately. If Joe is not found nearby, a call will be made to the local police department and his mother will be notified. When in the community he holds onto the arm or jacket of the person he is with while walking on sidewalks and crossing streets to ensure he doesn't walk into traffic and stays on the sidewalk. Whomever he is with will provide verbal prompts as necessary for safety. Joe's family checks the temperature of the water to make sure it is not too hot/cold for safe utilization. For evacuations, Joe needs verbal and physical prompts/gestures to evacuate in a timely manner and also to help him stay calm.

Question #7- ABC Agency: Any changes to his programming needs and/or services will be discussed with everyone so everyone is on the same page and is aware of these changes to ensure good quality services.

Question #8-ABC Agency: If at any time, a goal needs to be changed, discontinued, etc. this will be noted in his monthly progress report as well as in his ISP including reason for the changes with all updated information.

Individualized Service Plan (ISP)
Attendance Sheet
Addendum 1

Participant's Information

Name: Joe G

Address: 123 Main Rd. Anywhere, RI

Date of Birth 2/9/1982 Anniversary Date: 1/1/2013

Soc. Sec. No.: 000-00-0123 Phone No.: 555-1234

Meeting Information

Location: 1925 Giant Way

Date: 2/15/2013 Time: 2:00 PM

Joe G
Participant's Signature

Jane G (Mother)
Legal Guardian Name

Legal Guardian Signature

BHDDH Social Worker
Department Representative Name

Department Representative

ABC Agency
Agency/DDO Name #1

Agency/DDO Signature # 1

XYZ Agency
Agency/DDO Name #2

Agency/DDO Signature # 2

Agency/DDO Name #3

Agency/DDO Signature # 3

Name (Relationship to Participant)

Signature

Name (Relationship to Participant)

Signature

Name (Relationship to Participant)

Signature

Summary of ISP Goals/ Outcomes

Participant's Name Joe G Agency ABC & XYZ

Prior Year Period Not receiving services from BHDDH To _____

Upcoming Year Period 1/1/2013 To 12/31/2013

Prior Year Goals

Type of Goal Check all that apply:	Brief Description of Goal and Objective	Status of Goal		Outcome of Goal			Explanation of Outcome
		Continuing	Terminated	Fully Met	Partially Met	Not Met	
☐ Health	Joe will attend all medical appointmens Joe will take prescribed medication daily	☑	☐	☐	☑	☐	Joe is attending scheduled medical appointments
☑ Safety	Joe not able to cross street alone while in the community	☑	☐	☐	☐	☑	Joe is not able to cross street without staff
☑ Social	Joe will attend community outings 1x/week Joe will visit with friends	☑	☐	☐	☑	☐	Joe will continue with these goals Joe will continue with activities once a week
☑ Employment	Joe will volunteer for Meals on Wheels Joe will volunteer for Petalworks Joe will participant in the Art Program	☑	☐	☐	☑	☐	2x/week 2x/week 1x/week
☑ Other	Joe will help with household chores	☑	☐	☐	☑	☐	Joe is learning to cook 3 new meals

Summary of ISP Goals/ Outcomes

Upcoming Year Goals

Type of Goal Check all that apply:	Brief Description of Goal	Person(s) responsible to attain Goal
☑ Health	Joe will attend medical, vision and dental appointments	Agencies, Participant and family
	Joe will take prescribed medication daily	Agencies, Participant and family
☑ Safety	Joe will not cross the street alone while in the community	Agencies, Participant and family
☑ Social	Joe will participate in weekly visits with friend	ABC and Participant
	Joe will participate in one community outing per week	ABC and Participant
☑ Employment	Joe will volunteer for Meals on Wheels 2 days/week	ABC and Participant
	Joe will volunteer for Petalworks 1 day/week	ABC and Participant
	Joe will participant in the Art Program	XYZ and Participant
☑ Other	Complete one household chore per day	ABC, Participant and family

* Please add more pages if needed

Schedule of Services
Addendum 3

Name Joe G

Date of Birth 2/9/1982 Social Security Number 000-00-0123 Agency/DDO #1 ABC

Agency/DDO #2 XYZ Agency/DDO #3

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Mornings	ABC (7:30-8:30) Transport (8:30-9) have breakfast get dressed hygiene routine	ABC (7:30-8:30) Transport (8:30-9) have breakfast get dressed hygiene routine	ABC (7:30-8:30) Transport (8:30-9) have breakfast get dressed hygiene routine	ABC (7:30-8:30) Transport (8:30-9) have breakfast get dressed hygiene routine	ABC (7:30-8:30) Transport (8:30-9) have breakfast get dressed hygiene routine		
Day Hours	Day Program ABC 9-3pm ABC Transport 3-3:30	Day Program ABC 9-3pm ABC Transport 3-3:30	Day Program ABC 9-3pm ABC Transport 3-3:30	Day Program ABC 9-3pm ABC Transport 3-3:30	Day Program ABC 9-3pm ABC Transport 3-3:30		
Late Evenings	ABC (3:30-6:30) Visit with friends Help with dinner	ABC (3:30-6:30) Community Help with dinner	ABC (3:30-6:30) Help with dinner and household chores.	ABC (3:30-6:30) Help with dinner and household chores.	ABC (3:30-6:30) Help with dinner and household chores.		
Overnights							

Diagnosis Form
Addendum 4

Participant's Name Joe G

Date of Birth 2/9/1982

Social Security Number 000-00-0123

Address 123 Main Rd. Anywhere, RI

Diagnosis(es):

Developmental Disability: Physical and or cognitive disability. List all Diagnosis(es) with DSM and ICD codes. Also provide the name and qualifications of the professional making the diagnosis

Series	Diagnosis	Code	Qualifications of professional
DSM	Autism	299	Dr. Brown- Physician
ICD	Seizure Disorder	345	Dr. Smith- Neurologist

Psychiatric: List all Diagnosis(es) with DSM codes. Also provide the name qualifications of the professional making the diagnosis

Series	Diagnosis	Code	Qualifications of professional

Medical/Other: List all Diagnosis(es) with ICD and DSM codes. Also provide the name and qualifications making the diagnosis of the professional making the diagnosis

Series	Diagnosis	Code	Qualifications of professional